SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**September 28, 2005**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 130**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Robert Meeks; Sen. Gary Dillon; Sen. Rose Antich-Carr; Rep. Timothy Brown; Rep. Mary Kay Budak; Rep. David Frizzell; Rep. Charlie Brown; Rep. William Crawford; Rep. Peggy Welch.**

Members Absent: **Sen. Billie Breaux; Sen. Vi Simpson.**

Senator Patricia Miller, Chairperson, called the meeting to order at 1:06 p.m.

EDS Update

Mr. Dennis Vaughan, representing EDS, distributed a handout to the Commission containing the most recent Medicaid claim information. See Exhibit 1. The money paid for claims in the first two months of the fiscal year was more than at the same time last year. This increase is a result of the retroactive rate adjustments for payment of the nursing

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

facility quality assessment fee. The handout also contains new information that the Commission requested concerning claim inventory. The 9,900 claims that were received and awaiting data entry were the claims that were in the system on August 31, 2005 and not reflective of a failure to meet the prompt payment requirement. One of the top billing errors reflected on the handout is that the patient's spenddown was not met. When asked by the Commission as to whether this was a consumer error or a provider error, Mr. Vaughan responded that it would probably be a provider error since a provider is required to submit a form as proof that the patient's spenddown has been met. The Commission requested more information concerning the patient spenddown billing error.

The EDS handout also contained information on provider use of clearinghouses for batch claim submission. Mr. Vaughan explained that the use of a clearinghouse is optional within the state Medicaid program but that managed care organizations may require a provider to use a clearinghouse as part of the managed care organization's contract with the provider. Clearinghouses are commonly used in the healthcare industry as a cost effective means to ensure that claims are submitted in the proper format and to streamline payments. A Commission member stated that clearinghouses may not be actually be optional if all of the managed care organizations in a region require the use of a clearinghouse.

Pharmacy Reimbursement Rate Emergency Rule

Ms. Jeanne Labrecque, Director of Health Policy and Medicaid, informed the Commission of an emergency rule that will be published and effective October 1, 2005, concerning the Medicaid pharmacy reimbursement rate. Currently, pharmacists are reimbursed at the rate of Average Wholesale Price (AWP) minus 13.5%. Last month, FSSA had proposed an administrative rule changing this rate to AWP minus 19% with a state savings of approximately $10 million. FSSA has been meeting with the pharmacists and the emergency rule will reflect a compromise of a rate of AWP minus 16%, resulting in a state savings of approximately $6 million. The $4.90 dispensing fee will not change. Reimbursement for insulin will change. In response to why the reimbursement cut is occurring, Ms. Labrecque stated that the administration is trying to stop the bleeding that exists in the Medicaid program.

Disease Management Update

Dr. Thomas Inui, representing the Regenstrief Institute, provided the Commission with a preliminary evaluation report on Indiana's chronic disease management program. See Exhibit 2 for a copy of the Power Point presentation. The evaluation consists of two components: (1) a randomized controlled trial comparing patients covered under the disease management program with patients receiving usual care; and (2) a time-series evaluation comparing patients cared for in different regions of the state. The evaluation was limited because the disease management program only started in 2003. There has been little time for program maturation and little time for the disease management effects to emerge.

The average age of a disease management participant was 53.6 years and 73.9% of the participants were women. Seventy-nine percent of the participants had diabetes, 11% had congestive heart failure, and ten percent had both diseases. The disease management program was only able to reach a portion of the targeted population: 72% of the eligible members were reached in the first call by the call center. Nurse care managers who were sent to reach targeted high risk patients were only able to reach 41% of the individuals. Participants in the program receive education about the disease and the medication. High risk participants received nurse visits. The program saw an increase in drug costs--more patients were taking their medication-- and a decrease in hospital costs-- fewer and shorter hospitalizations for chronic heart failure patients. Patients may be living healthier

lives by participating in the program.

Dr. Inui presented the conclusions of the evaluation: (1) the program reduces Medicaid expenditures when offered to chronic heart failure patients; (2) the program modestly increased Medicaid expenditures for diabetic patients; (3) The time series data suggests that these costs are reflective statewide; (4) there was a clinically significant decrease in hemoglobin A1C, but the data is incomplete; and (5) the call center and nurse care managers may directly affect patient self-care to reduce costs and improve outcomes.

Dr. Monroe, State Health Commissioner of the Department of Health, stated that the disease management program has not been able to engage physician participation and that a statewide focus group has been created to attempt to pull the doctors into the program. Dr. Monroe informed the Commission that Indiana has been invited by the federal Centers for Disease Control and Prevention to be a pilot state for chronic disease management. The Commission asked Dr. Monroe to review the use of pharmacy benefit managers by the state to see whether the state is actually saving money.

Continuous Eligibility

Ms. Labrecque passed out a memorandum to the Commission describing continuous eligibility and lock-in. See Exhibit 3. In 1998 and until July, 2002, Indiana allowed continuous eligibility for Hoosier Healthwise program members (which includes most of the Medicaid population and the Children's Health Insurance Program) to be continuously eligible for the program for a twelve month period, without regard to changes in the recipient's family income or family size. Beginning in July, 2002, the state began to require individuals to notify caseworkers of any change that may affect eligibility. Eligibility for Hoosier Healthwise is now redetermined every twelve months. Last year, OMPP informed the Commission that no longer allowing continuous eligibility has saved the state $13 million. OMPP would like to reinstate continuous eligibility once the budget would allow for the reinstatement. In response to a question from the Commission, Ms. Labrecque stated that food stamp eligibility is determined every six months, and the income information obtained in determining food stamp eligibility is passed on to Medicaid.

Lock-In

States have the option of limiting a recipient's ability to change from one managed care plan to another. Currently, Indiana does not require managed care enrollees to stay with one plan for a specific period. Accordingly, a managed care recipient may change from one physician to another every month. The physician change may affect the managed care organization in which the recipient belongs. Indiana is currently determining whether to request this option in the future which would require federal approval and an amendment to the state's Medicaid waiver. Ms. Labrecque stated that the state would go through the regular rulemaking process if a decision is made to require lock-in and that a lock-in requirement would not be implemented before 2007.

Nursing Facility Reimbursement/Assessment

Ms. Labrecque informed the Commission that the nursing facility quality assessment amount varies depending upon the nursing facility's total resident days and non-Medicare days. The Commission requested that the office provide a by-facility breakdown of the charged assessment. As of September 28, 2005, $138 million in assessments have been paid for the period of July 1, 2003 through September 30, 2004 by 98% of the assessed nursing facilities. See Exhibit 4. The total assessment for the period of July 1, 2003 through June 30, 2005 is approximately $218 million. $272.5 million has been paid to the nursing facilities for the period of July 1, 2003 through September 30, 2004. The assessment will provide an additional $110 million per year to nursing facilities. These amounts are on target with what was anticipated in collections prior to implementation of

the assessment. Ms. Labrecque stated that FSSA will be starting the rulemaking process to change the case mix reimbursement formula to reflect the nursing facility quality assessment payments.

Ms. Labrecque informed the Commission that the emergency rule freezing nursing facility Medicaid reimbursement that FSSA was going to publish in October's Indiana Register will not occur. FSSA has agreed to continue discussing the reimbursement rates with the advocates. FSSA had requested the freeze because of budgetary limitations. Currently, nursing facility reimbursement averages approximately $105 per day, not including the quality assessment payment. If FSSA did not freeze the rate and allow the average six percent increase, reimbursement would be an average rate of $112 per day, not including the quality assessment payment. If the freeze were to occur, but factoring in the quality assessment payment, the nursing facilities would be reimbursed on average approximately $122 per day. The freeze would affect nursing facilities for different lengths of time, depending upon when the nursing facility files the facility's cost report. See Exhibit 4 for more information.

Jim Leich, representing the Indiana Association of Homes & Services for the Aging, stated that he is looking forward to working with the state to come up with alternative means to save money without implementing a reimbursement freeze. Mr. Leich stated that his members lose approximately ten dollars to $15 per day for Medicaid patients.

Faith Laird, representing the Indiana Health Care Association, thanked FSSA for agreeing to delay the freeze and urged the Commission not to recommend a reimbursement rate freeze. Ms. Laird also commented that she would like to see the quality assessment fee extended for another three to five years. Ms. Laird stated that it is hard for nursing facility owners to plan ahead because of the lack of stability in the nursing facility reimbursement system. A freeze would kill any incentive for a nursing facility owner to make improvements to the facility. Ms. Laird informed the Commission that Indiana needs to be better in leveraging federal funds, giving the example of certifying the Veteran's Home to receive Medicaid.

Bob Decker, representing Hoosier Owners and Providers for the Elderly, stated that he agrees with his colleagues concerning the impact of a rate freeze. Mr. Decker also stated that he thought the six percent increase calculation by FSSA was a conservative projection and was not sure if that figure is correct.

Bill Hartung, representing the Board of Directors of the Clinton House, stated that he appreciated the state's delay in implementing the freeze. Mr. Hartung provided the Commission with background information about the Clinton House and stated that Clinton House has been using the quality assessment payments to provide health insurance and pay raises for the nursing facility's employees. Clinton House has also paid overdue bills and constructed a new parking lot for visitors. Mr. Hartung stated that the industry needs stability in the reimbursement rate system.

Steve Albrecht, representing Beverly Healthcare, requested a three to five year extension of the nursing facility quality assessment. Mr. Albrecht stated that a nursing facility reimbursement freeze would affect wages, capital improvement projects, and specialty units that have increased costs. Mr. Albrecht also stated that he is not sure how FSSA calculated the six percent increase figure.

Janet Clancy, representing Kindred Healthcare, stated that the quality assessment fee helps nursing homes because the cost of daily care is not covered by the Medicaid reimbursement rates. Individuals are entering nursing homes more ill and more nurses

are needed to take care of the individuals.

Representative Crawford asked Senator Miller to clarify the procedure that the Commission will use in reviewing the issue of nursing home reimbursement rates.

Cash and Counseling Medicaid Waiver

Representative Frizzell explained the concept behind the Medicaid Cash and Counseling waiver and stated that he believes that the cost issue should be neutral. Other states such as New Jersey and Florida have found success in using the Medicaid cash and counseling waiver. Representative Frizzell stated that control over the money being spent on services should result in happier patients. Representative Frizzell informed the Commission that he will be introducing this bill again this session. Mr. John Okeson, FSSA, stated that their opposition in the past has been that FSSA does not have sufficient staff to apply for the waiver and that the application process is a cost to FSSA. However, Mr. Okeson informed the Commission that Secretary Roob, FSSA, does like parts of the waiver and will discuss the draft and revisit the matter with the Commission at the next meeting.

Commission members requested that certifying the Veteran's Home for Medicaid be prepared as a draft for Commission action at the next meeting. The next meeting will also include discussion on long term care insurance and action on any proposed bill drafts.

The meeting adjourned at 3:55 p.m.